

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

1696-63-009129
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

FILED FEB 21 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Riverview Gardens	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Christian Hospital		d. STREET ADDRESS (If outside, give location) 324 Fork Dr.	

3. NAME OF DECEASED (Type or print) First Middle Last Hosken B. Mustaine			4. DATE OF DEATH Month Day Year Feb. 15, 1963		
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-25-85	9. AGE (last birthday) 77	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (City and state or country). Horse Cave, Ky.	
12. CITIZEN OF WHAT COUNTRY U. S.		13a. FATHER'S NAME William P. Mustaine		13b. MOTHER'S MAIDEN NAME Leona Hosken	
14. NAME OF HUSBAND OR WIFE Lou M. Mustaine		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of serv) No		16. SOCIAL SECURITY NO. 5020	
17. INFORMANT Lou. M. Mustaine, 324 Fork Dr.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO (b) Hypertension of the Lesser Circulation DUE TO (c) Chronic Bronchitis & Emphysema		INTERVAL BETWEEN ONSET AND DEATH 6 months 1 year + 5 years +	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from July, 1960 to Feb. 15, 1963 and last saw him alive on Feb. 14, 1963 Death occurred at 1:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Syvester A. Platte M.D.		22b. ADDRESS 302 Northland Med. Bldg		22c. DATE SIGNED 2/15/63	

23a. BURIAL CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-18-63		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
23d. LOCATION (City, town, or county) Normandy, Mo.		24. FUNERAL DIRECTOR White-Mullen Mortuary, Ferguson, Mo.		25. DATE REC'D BY LOCAL REG. FEB 16 1963	
26. REGISTRAR'S SIGNATURE R. Smith		27. REGISTRAR'S SIGNATURE R. Smith			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Rudolf X. Lehmann

Licensed Embalmer No. 3395

P. O. Address St Louis 35 MO

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.